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Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declarations on HIV/AIDS

United to end AIDS: achieving the targets of the 2011 Political Declaration

Report of the Secretary-General

Summary

This is the first report to the General Assembly since the High-level Meeting on HIV/AIDS, held in June 2011. At that meeting, which reviewed progress made during the previous decade, Member States embraced the vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths. The 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, provides a road map towards this vision, adopting 2015 as the deadline for achieving concrete results. Member States pledged to deliver antiretroviral therapy to 15 million people living with HIV; work towards eliminating new infections in children and substantially reducing maternal AIDS-related deaths; reduce by 50 per cent new infections from sexual transmission and among people who inject drugs; substantially increase HIV funding, with the goal of mobilizing $22 billion to $24 billion annually; meet the needs of women and girls; and eliminate stigma and discrimination.

Today the international community has cause for hope and optimism in the response. Access to essential treatment and prevention services has increased, new infections and AIDS-related deaths are on the decline, and young people in high-prevalence countries are increasingly adopting safer sexual behaviours. With recent research results indicating that antiretroviral treatment reduces by 96 per cent the risk of HIV transmission within couples in which one partner is living with HIV and the other uninfected, leaders have begun speaking of a possible "beginning of the end of AIDS". Yet at this unprecedented moment, critical challenges remain. Substantial access gaps persist for key services, with especially difficult obstacles experienced by populations at higher risk. Punitive laws, gender inequality, violence against women and other human rights violations continue to undermine national responses. Of special concern is the first-ever decline in HIV funding in 2010,

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potentially jeopardizing the capacity of the international community to close access gaps and sustain progress in the coming years. Continued work is needed to maximize synergies and impact between HIV and broader health and development programmes.

The report summarizes results against the targets in the 2011 Political Declaration on HIV and AIDS. Although striking progress has been achieved, the world is not on track to meet the 2015 targets, underscoring the urgent need for all stakeholders to redouble their efforts to strengthen the HIV response.

Efforts must be refocused to achieve real results and end a global epidemic of historic proportions. The response must be smarter and more strategic, streamlined, efficient and grounded in human rights. To accelerate gains and seize new opportunities generated by scientific research, it is essential to recognize the shared responsibility for the response. International donors, emerging economies, affected countries and additional stakeholders must all actively contribute, in accordance with their respective capacities. As additional resources are mobilized and essential programmes brought to scale, intensified efforts should lay the foundation for increased ownership and sustainability of the response in sub-Saharan Africa. Courage and commitment will also be needed to tackle the challenges that continue to undermine progress, including a lack of access to social justice, equality and equity.

After more than three decades of struggle, success is finally in sight.

I. Introduction

1. Uniting around the shared vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths, Member States reaffirmed their collective commitment to achieving concrete results in the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. Specifying targets for 2015, the Political Declaration pledged to deliver antiretroviral therapy to 15 million people, eliminate new infections in children and achieve 50 per cent reductions in sexual transmission, maternal deaths and tuberculosis-related deaths among people living with HIV. Member States further committed to closing the resource gap, meeting the needs of women and girls, eliminating stigma and discrimination and promoting the integration of the HIV response in broader health and development efforts.

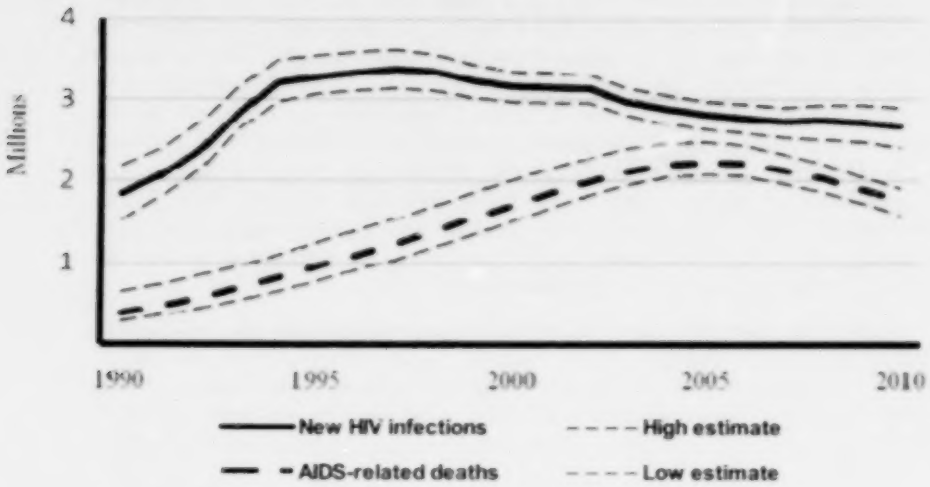
2. Substantial gains have been achieved in the response over the last decade, including heartening advances during the past 12 months. However, the current response is unlikely to result in the ambitious 2015 targets being reached. Recent declines in global spending underscore the critical need to redouble efforts to mobilize the resources necessary to achieve targets related to coverage for essential HIV services.

3. Achieving the 2015 targets is vital to the future health and well-being of our world. In the fourth decade of the global struggle against AIDS, there are available a wider array of lessons learned and a broader spectrum of effective tools than ever before. With less than four years until these targets are due, intensified commitment, evidence-based action and strategic focus are urgently needed.

4. AIDS remains one of the great challenges of our times. More people than ever, an estimated 34 million (31.6 million-35.2 million) as of December 2010, are living with HIV. Sub-Saharan Africa remains most heavily affected, accounting for 68 per cent of all people living with HIV and 70 per cent of all people newly infected in 2010. Women make up 50 per cent of adults (age 15-49) living with HIV globally and 59 per cent of all infections in sub-Saharan Africa. The impact on young women (age 15-24) in sub-Saharan Africa is particularly acute, with 72 per cent of young people infected being women. As at December 2010, an estimated 16.6 million children had lost one or both parents to AIDS — nearly 15 million of those children reside in sub-Saharan Africa.

5. Fewer people are dying of AIDS-related causes (see figure I). In low- and middle-income countries, antiretroviral treatment has averted 2.5 million deaths since 1995. Annual AIDS-related deaths (1.8 million [1.6 million-1.9 million] in 2010) have fallen by 18 per cent since the mid-2000s.

Figure I
New HIV infections and AIDS-related deaths, 1990-2010



Source: UNAIDS World AIDS Day Report 2011.

6. The number of people newly infected in 2010 (2.7 million [2.4 million-2.9 million]) was 21 per cent lower than the peak in 1997. However, the number of people newly infected remains far too high to meet the agreed 2015 target of reducing new infections by 50 per cent.

7. The number of children newly infected in 2010 (390,000 [340,000-450,000]) was 30 per cent lower than the peak in 2002 and 2003. Since 1995, prevention services are estimated to have averted 350,000 new infections in children.

8. Young people age 15-24 account for 42 per cent of new infections among people 15 years and older worldwide. Here, too, progress is evident. In 21 of 24 countries with HIV prevalence of 1 per cent or greater, significant declines in HIV prevalence among young pregnant women (age 15-24) have been documented over the past decade. Favourable changes in sexual behaviour have been associated with delay in sexual initiation, reduction in multiple partners and increased condom use. In 11 of 19 African countries studied, the percentage of young men with multiple partners in the last 12 months has fallen significantly.

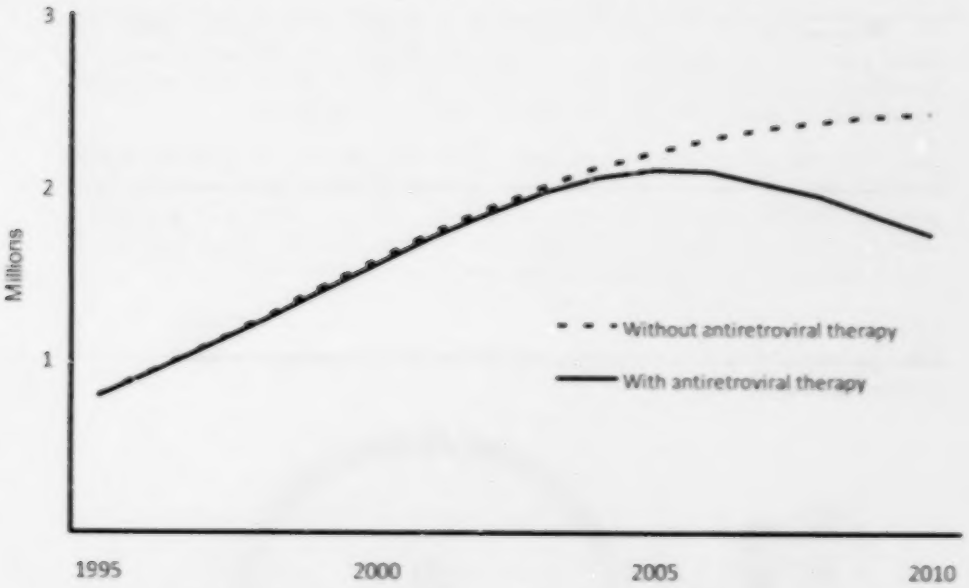
9. Epidemics vary considerably within and between countries and regions. While new infections are on the decline in sub-Saharan Africa and the Caribbean, HIV incidence is rising in Eastern Europe and Central Asia, in the Middle East and North Africa and in certain Asian countries. Regionally, the epidemic appears to have stabilized in Asia, Latin America, North America and Western and Central Europe.

10. Rates of AIDS-related deaths also vary. For example, while AIDS-related mortality has fallen substantially in sub-Saharan Africa, no decline has been reported in Asia. These disparities reflect differing degrees of success in bringing treatment to scale in low- and middle-income countries. Moreover, HIV remains a leading cause of death among women of reproductive age globally. While antiretroviral treatment coverage in 2010 reached 63 per cent [57-74 per cent] in

Latin America and the Caribbean and 56 per cent [53-59 per cent] in Eastern and Southern Africa, coverage was much lower in East, South and South-East Asia (39 per cent [36-44 per cent]), Western and Central Africa (30 per cent [28-33 per cent]), Eastern Europe and Central Asia (23 per cent [20-26 per cent]), and the Middle East and North Africa (10 per cent [8-13 per cent]). In low- and middle-income countries, treatment coverage is substantially higher among adults (51 per cent [48-54 per cent]) than in children (23 per cent [20-25 per cent]). In low- and middle-income countries, in the period 1995-2010 2.5 million deaths from AIDS-related causes were averted with the use of antiretroviral therapy (see figure II).

Figure II

Deaths from AIDS-related causes in low- and middle-income countries, 1995-2010



Source: World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund, *Global HIV/AIDS Response Progress Report 2011*.

11. HIV prevalence and incidence tend to be elevated in populations at higher risk, in both concentrated and generalized epidemics. This reflects their lack of access to proven prevention tools, attributable in large part to the effects of punitive laws, abusive police practices and high levels of stigma and discrimination. Unprotected paid sex continues to have a major impact on the spread of HIV in sub-Saharan Africa, including in mature epidemics, and high levels of infection among sex workers have also been reported in other regions. Injecting drug use persists as an epidemic driver in Eastern Europe and Central Asia and contributes to the expansion of the epidemic in other regions. In addition, a worldwide epidemic has been documented among men who have sex with men, including in sub-Saharan Africa.

II. Key targets for 2015: progress to date and challenges to overcome

12. The following information describes progress made to date towards achieving the targets in the 2011 Political Declaration on HIV and AIDS, identifies obstacles that need to be overcome and describes key action steps to accelerate progress. Figures III to XII indicate the changes required in each region to reach various 2015 targets, based on available data and modelling by the Joint United Nations Programme on HIV/AIDS (UNAIDS).

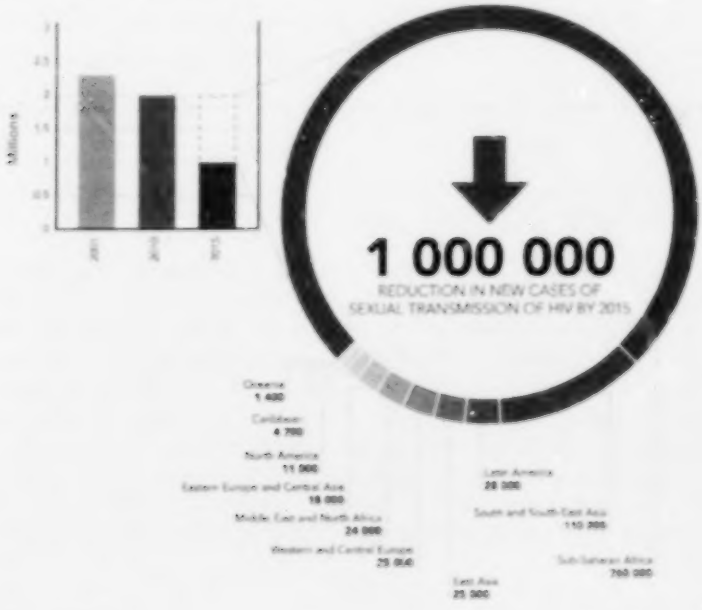
A. Reduce sexual transmission of HIV by 50 per cent

13. Slowing the rate of sexual transmission is vital to achieving the vision of a world with zero new infections, as sexual transmission remains the primary mode of transmission globally. To meet the 2015 target, the annual number of new sexually transmitted infections will need to decline by at least 1 million.

14. Over the past decade, historic gains have been achieved in reducing sexual transmission, especially in numerous hyperendemic countries. In 22 countries, HIV incidence fell by more than 25 per cent between 2001 and 2009. HIV prevalence among pregnant women attending antenatal settings declined by an average of 31 per cent in 24 high-prevalence African countries from 2000 to 2010.

Figure III

Changes required to meet the target of a 50 per cent reduction in sexual transmission by 2015



Source: UNAIDS.

15. Effective prevention of sexual transmission builds on a foundation of knowledge and skills, respect for human rights, a commitment to gender equality and the elimination of sexual violence and the greater involvement of people living with HIV. Sound prevention programmes include the strategic combination of behavioural, biomedical and structural interventions, with robust investments in basic, high-impact programmatic activities and enabling policies.

16. The widespread adoption of safer sexual behaviours has driven declines in HIV incidence in many high-prevalence settings, although considerable challenges remain. Fewer than half of young people surveyed in Africa have accurate and comprehensive knowledge of HIV, and fewer than 10 male condoms are available for every man in sub-Saharan Africa annually, with considerable variation in condom access among countries.

17. Urgent efforts continue to generate new biomedical prevention tools. In 2011, two major clinical trials in sub-Saharan Africa found that a daily regimen of antiretroviral prophylaxis significantly reduced the risk of HIV acquisition among uninfected heterosexual adults. Less promising were study results in late 2011 that failed to demonstrate any prevention benefit from daily use of a vaginal antiretroviral-based microbicide. However, additional analyses of these trial data suggest that suboptimal adherence may be at least partially responsible for these disappointing results. Efforts must persist to develop new, safe and effective methods to reduce women's risk of sexual HIV transmission, including new forms of female condoms.

18. Evidence that antiretroviral treatment substantially reduces the risk of transmission underscores the need to enhance the integration of programming for HIV prevention, diagnosis and treatment. Moving to capture the prevention benefits of early initiation of antiretroviral treatment, 43 of 52 countries surveyed had, as at December 2010, revised their national criteria for when to start antiretroviral therapy.

19. A growing body of evidence is informing efforts to address the social and structural determinants of HIV. New data indicate that cash transfers help to reduce the vulnerability of young people to HIV; schooling is a protective factor, especially for girls; and laws and law enforcement practices affect access to services for key populations.

20. To date, populations at higher risk have not received the attention required to ensure their access to evidence-informed HIV prevention. Studies clearly demonstrate the effectiveness of rights-based prevention programmes focused on key populations. In 2011, the World Health Organization (WHO), in partnership with the United Nations Development Programme (UNDP), UNAIDS and other institutions, issued its first-ever guidelines for the prevention of HIV and other sexually transmitted infections among men who have sex with men, and transgender people. Other populations in urgent need of focused prevention support include women, young people, people in prison settings, migrants, populations in humanitarian crises, and sex partners of people who inject drugs or sell sex.

21. Although international human rights protections prohibit discrimination in the provision of health services, the access of key populations to prevention services remains extremely limited in many parts of the world. In sub-Saharan Africa, for example, most countries report having no individual- or community-level

behavioural interventions focused on men who have sex with men. Globally, at least 18 countries do not support the targeted promotion of condoms for sex workers, a key component of comprehensive prevention programmes for that population. This discriminatory neglect must end.

22. In 13 African countries with high HIV prevalence and low prevalence of male circumcision, studies indicate that achieving 80 per cent coverage of adult medical male circumcision would avert more than 20 per cent of new infections by 2025 and save an estimated $16.6 billion in future medical costs. However, only 5 per cent of eligible adult men had been circumcised as at December 2010, although uptake accelerated in 2010. Over the last year, studies have been launched or planned in several countries to evaluate new circumcision devices that offer a potential avenue to increase demand and expedite scale-up.

23. Intensified HIV prevention efforts are needed to protect women from becoming infected. After a 2011 study in sub-Saharan Africa found that women's use of injectable progestogen-based hormonal contraception increased the risks of HIV transmission and acquisition within serodiscordant couples, international health experts determined that available evidence was inconclusive and did not warrant advising women to avoid hormonal contraception. However, women using progestogen-only injectable contraception are strongly advised to use condoms and other preventive measures. Further research on the relationship between hormonal contraception and HIV infection is essential.

24. Although surveys in several countries indicate that more young people are delaying their sexual debut, stronger, better-focused prevention efforts are needed, as young people under age 25 account for more than 4 in 10 new infections. Accurate knowledge of prevention remains low, and sexual and reproductive health information, comprehensive sexuality education and health services need to be tailored to the needs of young people and made accessible to them. Young people should be actively engaged in the development and implementation of policies and programmes that affect them; intensified efforts should focus on cultivating a new generation of HIV leaders; and social networking, media and other innovative tools should be employed to build the demand of young people for services.

B. Reduce HIV transmission among people who inject drugs by 50 per cent

25. With an estimated 240,000 people who inject drugs being newly infected with HIV each year, the number of incident infections in this population must fall by at least 120,000 to meet the 2015 target and contribute towards the vision of a world with zero new infections. Transmission as a result of drug use is entirely preventable through the implementation of a package of proven prevention methods, including needle and syringe exchange programmes, opioid substitution therapy and comprehensive health and social support services.

26. There is a critical need to intensify prevention efforts and review current methods. In 2010, only 43 of 109 countries reported that they had any needle or syringe exchange programme in place, and only 58 countries provided opioid substitution therapy. Even where such services are available, coverage remains extremely low.

27. A rights-based approach is vital for all people living with or affected by HIV and is especially critical for people who inject drugs. Many people who inject drugs avoid health and social services owing to criminalization, overt discrimination and abusive law enforcement practices. As people who inject drugs and other low-income or socially marginalized people are often unable to pay out-of-pocket expenses for HIV services, meaningful access to services for such individuals requires non-discriminatory and non-stigmatizing social protection, outreach and universal health coverage.

Figure IV

Changes required to meet the target of a 50 per cent reduction in the number of new HIV infections among people who inject drugs

Source: UNAIDS.

C. Eliminate new infections in children and substantially reduce AIDS-related maternal deaths

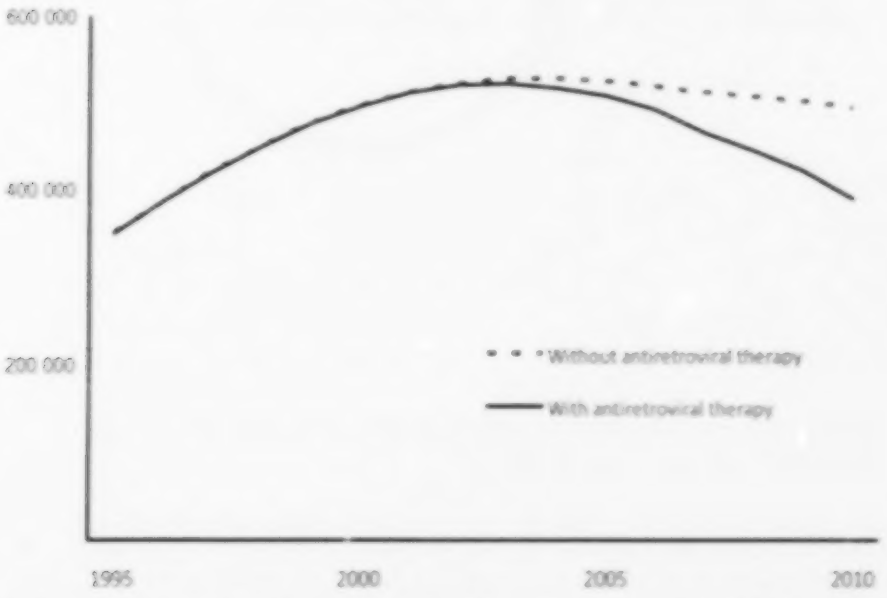
28. Achieving a world with zero new infections demands concerted efforts to protect children and promote the health and well-being of their mothers. To eliminate new infections in children and cut AIDS-related maternal deaths by 50 per cent by 2015, partners will need to implement a four-point plan outlined in the UNAIDS Global Plan Towards the Elimination of New Infections among Children by 2015 and Keeping Their Mothers Alive: (a) prevent HIV infection in women and girls; (b) close the access gap for women's family planning services, especially for those living with HIV; (c) implement the recommended package of services to ensure that pregnant women and their newborns obtain antiretroviral prophylaxis to reduce the risk of HIV transmission during pregnancy, delivery or breastfeeding;

and (d) ensure universal access to HIV treatment, care and support for women and children living with HIV, as well as their families. As comprehensive services help address barriers to service uptake and adherence, elimination programmes should be integrated with broader services for women's and children's health and nutrition.

29. Urgent efforts are needed to eliminate access gaps in services to prevent new infections in children. In 2010, 48 per cent of HIV-positive pregnant women in low- and middle-income countries received an effective combination antiretroviral prophylaxis to prevent transmission to their newborns. In 5 of the 22 countries prioritized in the Global Plan (Botswana, Lesotho, Namibia, South Africa and Swaziland), coverage with effective antiretroviral regimens exceeded 80 per cent. Efforts to prevent new infections in children urgently require strengthened prevention services for women, especially pregnant women who may be at higher risk, as well as immediate steps to meet the need for family planning services among all women, including HIV-positive women, while respecting their reproductive rights. In low- and middle-income countries, more than 350,000 new HIV infections among children were averted through antiretroviral prophylaxis in the period 1995-2010.

Figure V

Reduction of new HIV infections among children through antiretroviral prophylaxis in low- and middle-income countries, 1995-2010



Source: WHO, UNAIDS, UNICEF, *Global HIV/AIDS Response Progress Report 2011*.

30. Programmatic shortcomings that undermine the impact of prevention programmes need to be immediately addressed. In six high-prevalence countries in sub-Saharan Africa, unmet need for family planning services among HIV-positive women ranges from 12 per cent to 21 per cent, according to surveys undertaken from 2006 to 2010. Children continue to lag in access to treatment, with only 23 per

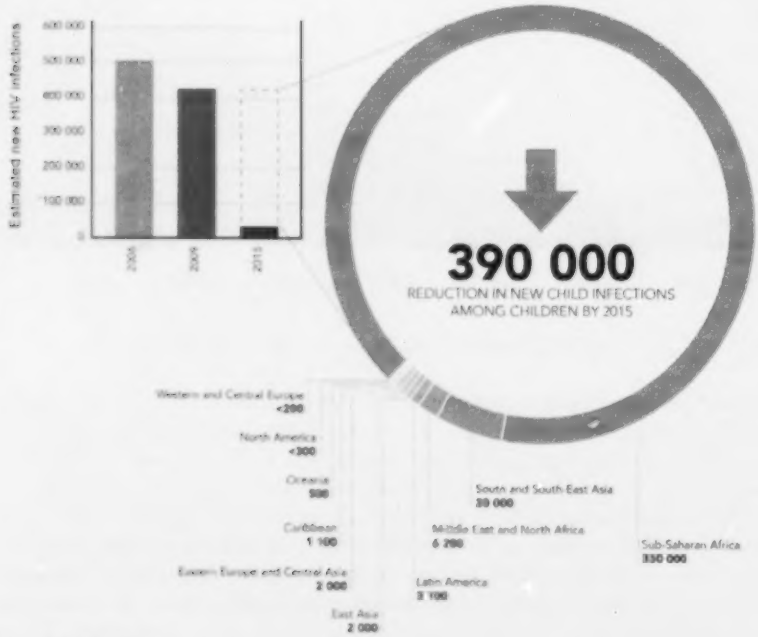
cent of treatment-eligible children receiving antiretroviral therapy in 2010. Owing to persistent access gaps and use of suboptimal prophylactic regimens, only a modest decline in the transmission rate to children has been reported — from 29 per cent of children born to HIV-positive mothers in 2009 to 26 per cent in 2010.

31. In 2010, only 34 per cent of treatment-eligible women received antiretroviral therapy for their own health. Mothers of newborns in high-income countries generally benefit from treatment, allowing them to remain productive and keep their families together. Experience in all regions indicates that a family-centred approach is most effective in advancing the linked goals of reducing new infections in children, optimizing health outcomes for women and children living with HIV, reducing the number of children orphaned by AIDS and minimizing poverty among HIV-affected households.

32. In many countries, HIV-positive pregnant women are receiving suboptimal drug regimens to prevent transmission to their babies. In the 22 countries that account for the overwhelming majority of new infections among children, 13 per cent of HIV-positive pregnant women were prescribed single-dose nevirapine in 2010, and roughly one in three received the optimal dual prophylaxis. Eliminating the use of suboptimal regimens would prevent an estimated 20 per cent of all new infections in children.

Figure VI

Changes required to meet the target of virtually eliminating new HIV infections among children

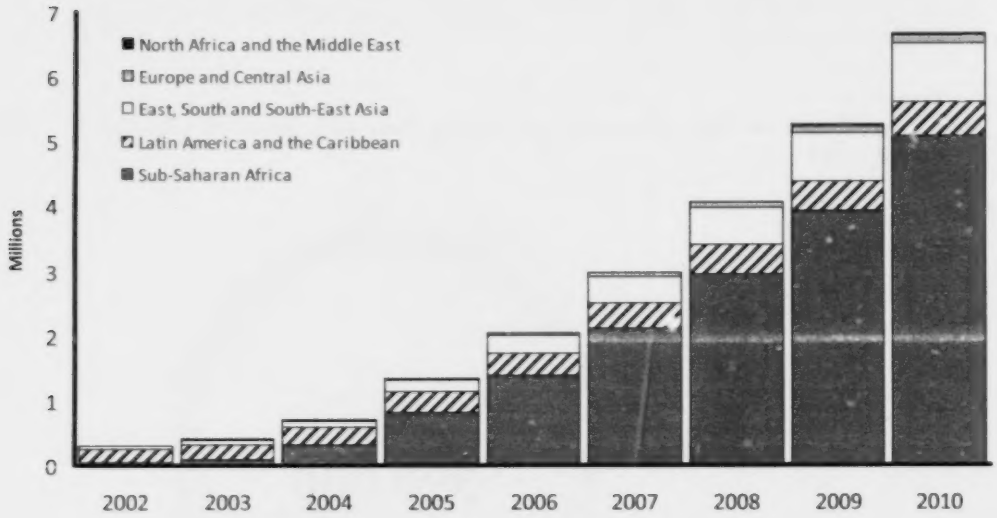


Source: UNAIDS.

D. Reach 15 million people living with HIV with antiretroviral treatment

33. While redoubling efforts to prevent new infections, renewed determination is needed to promote the health and quality of life of people living with HIV. The rapid expansion of antiretroviral therapy in low- and middle-income countries represents one of the most important achievements in global health and has engendered hope in the vision of a world with zero AIDS-related deaths. In a single decade, the number of people in low- and middle-income countries receiving antiretroviral therapy has increased more than 20-fold. Coverage for antiretroviral treatment reached 47 per cent in low- and middle-income countries in 2010. To achieve the 2015 targets, the number of people receiving antiretroviral treatment will need to increase by 57 per cent compared with 2010.

Figure VII
Number of people receiving antiretroviral therapy in low- and middle-income countries, by region, 2002-2010

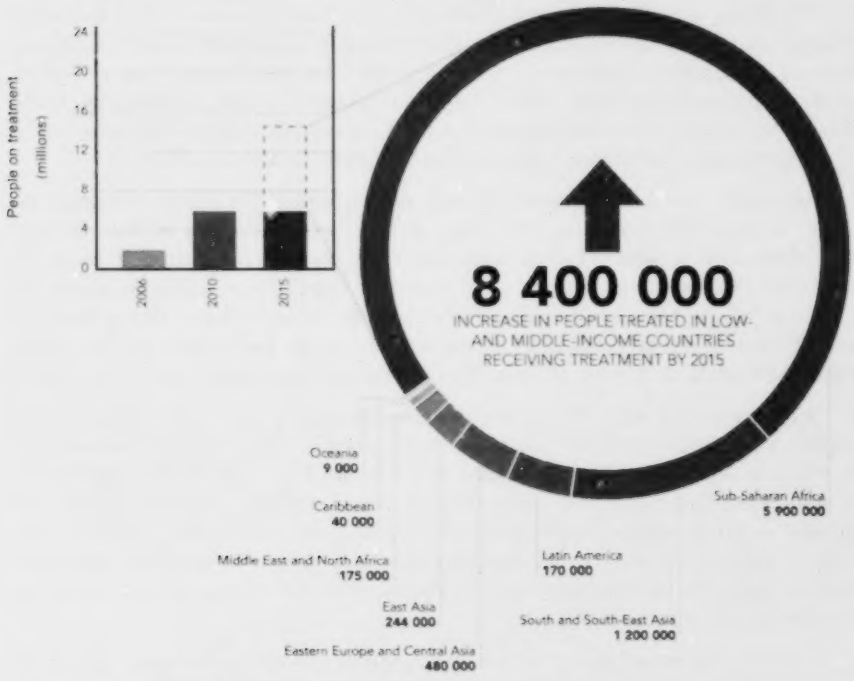


Source: WHO, UNAIDS, UNICEF, *Global HIV/AIDS Response Progress Report 2011*.

34. Reaching the target of providing antiretroviral treatment to 15 million people by 2015 will require substantially greater progress across the entire diagnostic and treatment continuum. Although testing and counselling is the gateway to treatment, many people living with HIV remain unaware of their infection. Globally, the number of facilities offering testing and counselling services increased by 18 per cent in 2010. In a drive to increase the number of people who know their serostatus, efforts have been made to extend testing services beyond stand-alone voluntary counselling and testing centres, using provider-initiated testing in health-care facilities, community-based door-to-door testing campaigns, workplace testing programmes and technologies that permit self-testing at home.

Figure VIII

Changes required to meet the target of providing antiretroviral treatment to 15 million people living with HIV in low- and middle-income countries, by 2015



Source: UNAIDS.

35. Testing must always be linked to counselling and treatment. An estimated 41 per cent of people in sub-Saharan Africa who test positive do not receive CD4 monitoring tests or clinical staging, and 32 per cent determined to be eligible for antiretroviral treatment do not receive medications. Financial barriers to treatment access, such as user fees and heavy transportation costs, should be eliminated.

36. In resource-limited settings, food and nutrition support can be a cost-effective investment to enhance treatment success and to mitigate the consequences of HIV and tuberculosis on livelihoods, by reducing early mortality, supporting nutritional recovery, promoting treatment adherence and improving retention in care. Treatment should be accompanied by nutritional assessments, nutritional education and counselling and treatment for malnutrition.

37. Particular efforts are needed to ensure treatment access for populations at higher risk, who often experience access barriers owing to stigma and discrimination. Cambodia has implemented a comprehensive service continuum for these populations and has enhanced linkages between treatment programmes and community outreach initiatives.

38. People living with HIV among populations affected by humanitarian emergencies should have similar access to treatment as the surrounding host

communities. It is necessary to confront the increased risk and vulnerability of people in conflict and post-conflict settings and to ensure that HIV programmes become an integral part of all disarmament, demobilization, reintegration and peacebuilding processes and security-sector reforms.

39. Improving the efficiency and effectiveness of treatment services is central to long-term success in the response. The Treatment 2.0 framework aims to accelerate treatment scale-up and improve health outcomes by optimizing drug regimens, providing point-of-care and other simplified diagnostic and monitoring tools, reducing treatment costs, adapting service delivery models through decentralization and integration and mobilizing communities to support treatment efforts.

40. Advances have been reported towards the Treatment 2.0 vision. Although the use of the more toxic antiretroviral drug d4T in first-line regimens has declined since 2006, surveys indicate that many countries are experiencing bottlenecks in introducing more superior alternative regimens, available as a single, once-per-day fixed-dose pill. In Mozambique, operational research demonstrated that a point-of-care CD4 testing device reduced by 50 per cent the number of people lost to follow-up and lowered the number of days needed to obtain a CD4 result from 27 to 1 day.

41. While prices of first-line antiretroviral treatments in low- and middle-income countries have fallen by more than 99 per cent over the past decade, treatment costs may rise again in future. Although only an estimated 3 per cent of patients in low- and middle-income countries, other than in the Americas, were on second-line regimens in 2010, demand will inevitably increase for second-line regimens that currently remain far more expensive than first-line drugs. In addition, paediatric antiretroviral formulations continue to be too expensive, fuelling the continuing lag in treatment access for children.

42. Ensuring the affordability of a broad range of antiretroviral drugs and drugs for co-infections, including hepatitis C, will demand simplified, standardized first- and second-line regimens that are harmonized for use across different adult and paediatric populations. Countries must also make effective use of flexibilities available under international intellectual property rules. The 2001 Doha Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health recognized the right of countries to take public health considerations into account to promote patients' access to priority medicines. A number of countries have already used TRIPS flexibilities to promote access to essential medicines, but even greater action will be needed, as many countries have yet to exercise the full array of access-promoting options available under international rules. Intensified efforts are needed to establish robust capacity in sub-Saharan Africa and other regions for the domestic manufacture of pharmaceuticals, and immediate consideration should also be given to the creation of an African regional authority for the regulation of medicines. As free trade agreements are negotiated, care should be taken by all parties to avoid the imposition of measures that limit the flexibilities now permitted under TRIPS. In 2011, the Medicines Patent Pool announced its first licence with a pharmaceutical company, permitting the generic manufacture of compounds produced by Gilead Sciences.

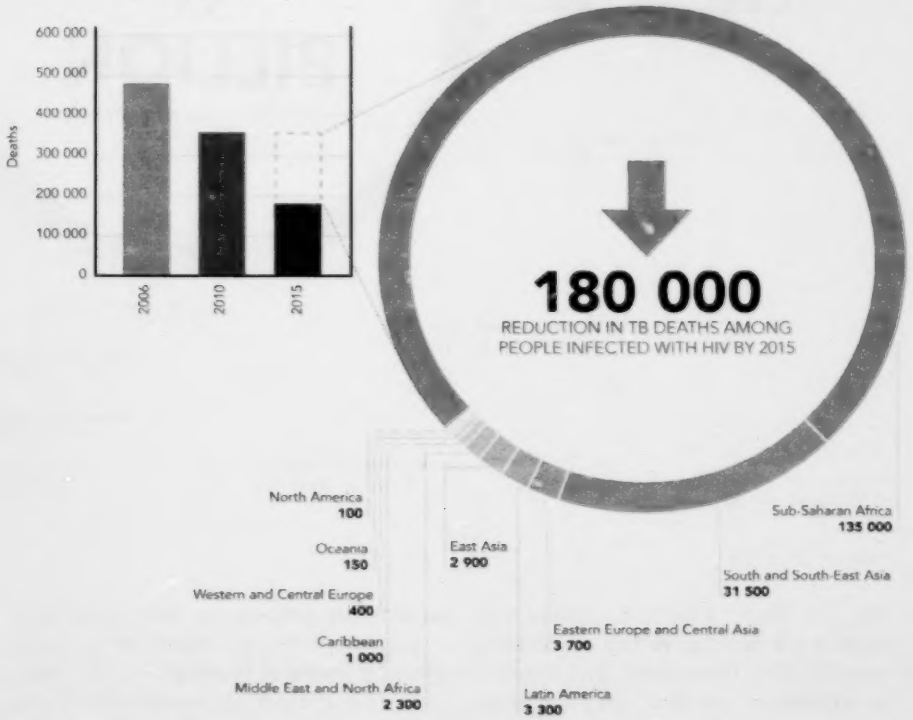
E. Reduce tuberculosis deaths among people living with HIV by 50 per cent

43. Achieving the vision of zero AIDS deaths requires success in efforts to prevent tuberculosis-related deaths among people living with HIV. Although the number of tuberculosis deaths among people living with HIV has declined for several years, tuberculosis remains a major cause of death for people living with HIV. In 2010, less than one in three people diagnosed with both HIV and tuberculosis accessed clinical care for tuberculosis.

44. In comparison with 2010, at least 180,000 fewer tuberculosis-related deaths among people living with HIV will be required by 2015 to meet the target in the 2011 Political Declaration on HIV and AIDS. From 2010 to 2015, tuberculosis cure rates should increase from 70 per cent to 85 per cent, rates of tuberculosis detection among people living with HIV must rise from 40 per cent to 80 per cent, and isoniazid preventive therapy needs to reach at least 30 per cent of people living with HIV who do not have active tuberculosis. According to recent modelling exercises, meeting these achievable aims would surpass the 2015 target, reducing tuberculosis-related deaths among people living with HIV by 80 per cent and saving a million lives.

Figure IX

Changes required to meet the target of reducing tuberculosis deaths among people living with HIV by 2015

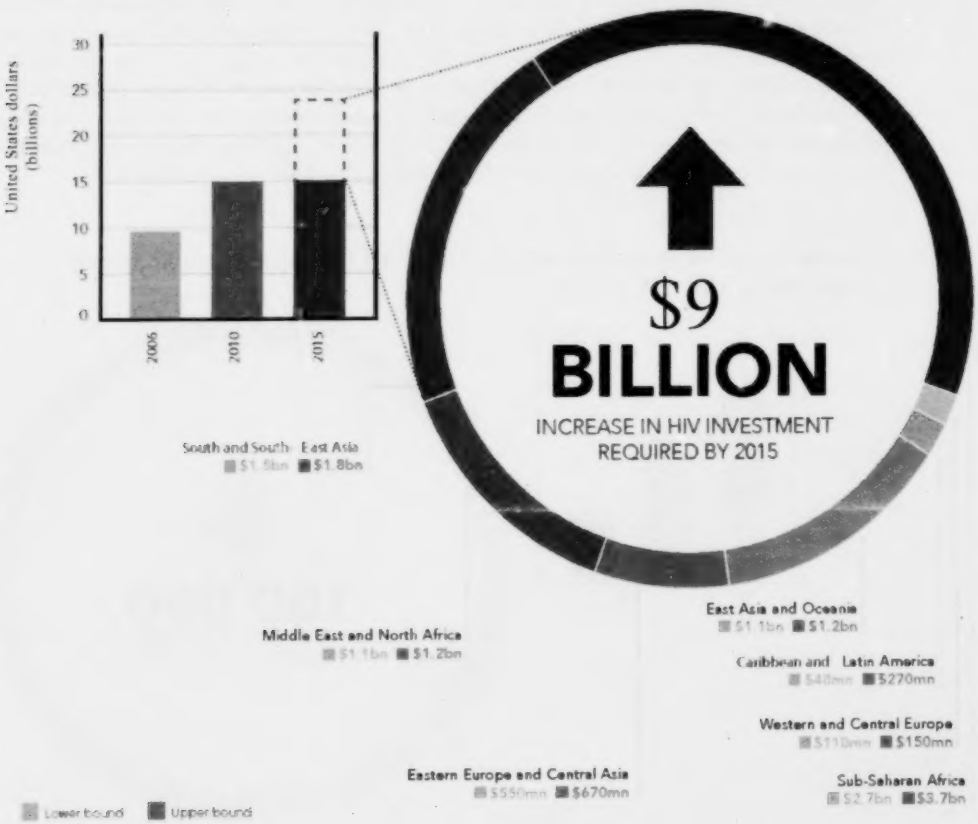


Source: UNAIDS.

F. Close the global AIDS resource gap and reach a significant level of expenditure

45. It will be impossible to achieve global targets without sufficient financial resources. Annual expenditure of $22 billion to $24 billion will be needed by 2015 to achieve the targets in the 2011 Political Declaration on HIV and AIDS. This will require a roughly 50 per cent increase over current outlays, as $15 billion was available for the HIV response in 2010.

Figure X
Changes required to meet the target of reaching $24 billion in HIV investment by 2015

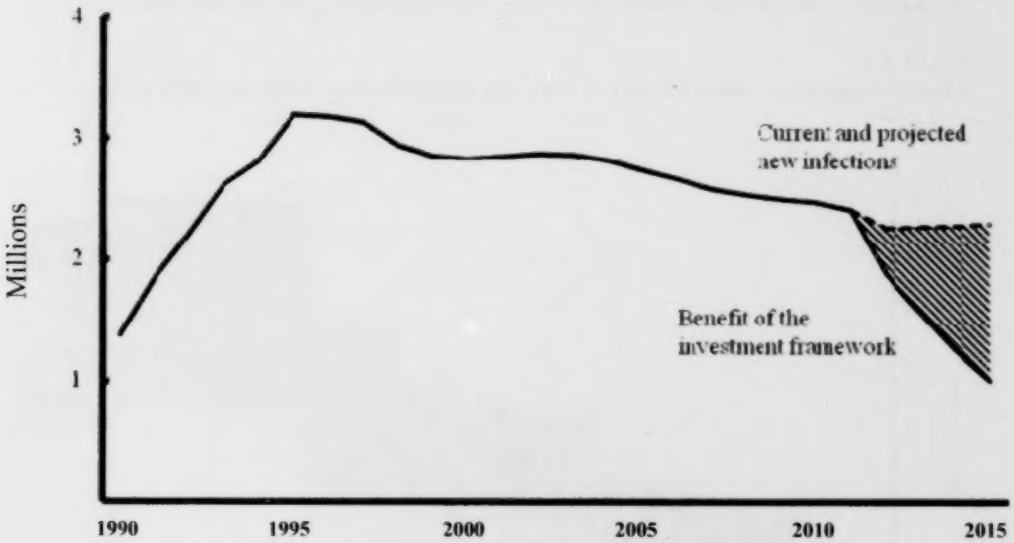


Source: UNAIDS.

46. In 2011, UNAIDS joined with partners to propose a new investment framework for the response, designed to promote efficiency while maximizing results. The investment framework encourages focused funding for six basic programmatic activities: (a) programmes for key populations; (b) elimination of new infections in children; (c) programmes for sexual risk reduction; (d) condom programming; (e) care, treatment and support for people living with HIV; and (f) voluntary medical male circumcision in priority countries. These basic

programmatic activities need to be supported by critical enablers and by well-resourced efforts to capture synergies between the HIV-specific and broader health and development initiatives. According to modelling exercises, improving the strategic use of resources according to the principles of the investment framework would avert 12.2 million new infections and 7.4 million AIDS-related deaths by 2020, with optimized investment leading to rapid declines in new HIV infections globally (see figure XI).

Figure XI
Investment framework projections for new HIV infections



Source: *UNAIDS World AIDS Day Report 2011*.

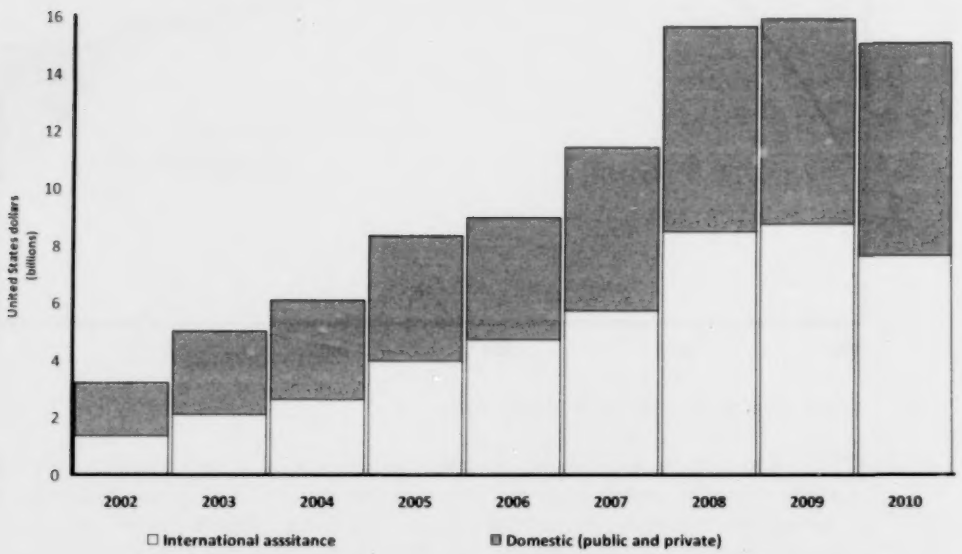
47. Urgent efforts are needed to enhance the effective and strategic use of expenditure and to mobilize needed resources. Where they exist, parallel systems of financing, procurement, programming and reporting should be eliminated to promote efficiency, harmonization and alignment. New sources of sustainable financing should be actively explored, including enhanced support from the private sector, the implementation of national social protection mechanisms, the enhanced use of regional development banks and a proposed tax on financial transactions.

48. The stakes involved in future financing for the response are vividly illustrated by recent difficulties at the Global Fund to Fight AIDS, Tuberculosis and Malaria, which cancelled a planned competitive call for proposals owing to funding shortfalls. A new contribution of $750 million to the Global Fund by the Bill and Melinda Gates Foundation, announced in 2012, serves as a critical vote of confidence in this essential funding mechanism. Consistent with the investment framework, the Global Fund has adopted a new model for negotiating grant agreements with countries, with the aim of focusing limited resources on cost-effective programmes that are tailored to local needs and likely to have the greatest impact.

49. By understanding the response as a shared responsibility, the global community will be able to ensure the financial means to achieve global goals. Were high-income countries to fulfil their pledges to devote 0.7 per cent of gross domestic product to official development assistance, the total resources available for development would more than double. With robust economic growth rates in sub-Saharan Africa, a decision by African Governments to raise the share of the health budget devoted to AIDS to reflect the relative burden of the epidemic in comparison with other diseases would generate an additional $4.7 billion for HIV activities. In addition, emerging middle-income countries, such as Brazil, China, India, the Russian Federation and South Africa, should continue actively exploring ways to provide increased financial assistance to other countries for the response.

Figure XII

Global resources available for HIV in low- and middle-income countries, 2002-2010



Source: *UNAIDS World AIDS Day Report 2011.*

G. Meet the specific needs of women and girls, eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

50. Accelerating progress in the response will demand sustained advances towards gender equality and the empowerment of women and girls. With women age 15-24 accounting for more than one in four new infections, and with nearly 60 per cent of infections in sub-Saharan Africa occurring among women, the 2011 Political Declaration on HIV and AIDS recognized the harmful effects of unequal gender norms and practices and pledged concerted action to eliminate gender inequalities.

51. Although there is growing awareness and commitment to take action to advance gender equality and empower women and girls, the gap between aspiration and reality remains considerable. While many countries acknowledge the effects of the epidemic on women and girls, less than half of countries worldwide have dedicated budgets for programmatic activities that address its gender dimensions. Increasing access to rights-based sexual and reproductive health services and empowering women to exercise their reproductive rights is a critical element of an effective response for women and girls. Access to quality education also reduces gender inequalities, demonstrating synergies between the HIV response and other development sectors.

52. Like their male counterparts, women and girls living with and affected by HIV are broadly diverse, demanding programmatic and policy responses that take their variations in needs and circumstances into account. In most regions, many women and girls either belong to key populations at higher risk of HIV infection, or are at risk of HIV infection as the sex partners of members of key populations.

53. Violence against women is both a root cause of HIV infection and a consequence of living with HIV, a fact that underscores the importance of urgent action to eradicate gender-based violence. According to recent household surveys, women who experienced sexual violence as a child were more than twice as likely as those with no such experience to have been diagnosed with a sexually transmitted infection in the previous 12 months and almost half as likely to use condoms. The UNiTE to End Violence against Women campaign calls for concerted action to eliminate gender-based violence by 2015, including the adoption and enforcement of appropriate national laws, the implementation of multisectoral national plans and other key steps. As at 2011, only 40 of 94 countries surveyed reported having a health-sector strategy that specifically addresses gender-based violence.

54. The UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV is galvanizing strong momentum to address the impact of the epidemic on women and girls. In recent months, numerous countries, including Benin, Lesotho, Morocco, Namibia, the United Republic of Tanzania and Viet Nam, have either developed national action plans on women, girls, gender equality and HIV, or taken other steps to address gender-related drivers of their national epidemic. Malaysia has implemented a "one-stop crisis centre model" for women who have experienced physical or sexual violence, offering client-sensitive services, counselling and legal, social and welfare services in the same setting. In India, a multilevel intervention was launched to prevent violence, harassment and stigma against sex workers and other key populations.

55. Men and boys also play a pivotal role in forging the healthy social norms of gender equality, which underscores the importance of programmes and policies that engage men and boys. In 2011, only 7 of 94 countries had dedicated national funding for scaled-up programmes involving men and boys that challenge gender inequalities.

H. Eliminate stigma, discrimination and violence against people living with and affected by HIV and HIV-related travel restrictions, through laws, policies, strategies and programmes that advance human rights

56. Persistent stigma and discrimination undermine progress towards global targets by deterring individuals from accessing HIV services and exacerbating the burdens on people living with HIV. In the Asia and Pacific region, for example, the percentage of people living with HIV who reported loss of employment or income as a result of HIV status ranged from 16-50 per cent, between 4-33 per cent have experienced reduced access to health care owing to stigmatizing attitudes among health-care professionals, and between 9-50 per cent have had their HIV status disclosed to friends or neighbours without their consent. HIV-related stigma reinforces other forms of stigma, such as those affecting populations at higher risk. Women living with HIV often experience harsher and more frequent stigma and discrimination than HIV-positive men.

57. The urgent need for intensified action to address HIV-related stigma and discrimination is apparent. One in every three countries in 2010 reported not having laws in place prohibiting discrimination against people living with HIV. A growing number of countries have enacted unsound and counterproductive laws criminalizing HIV non-disclosure, exposure or transmission, with high-income countries leading in actual prosecutions under such laws.

58. In 2010, 46 per cent of countries reported having laws, regulations or policies that impede key populations at higher risk of HIV infection from accessing prevention, treatment, care and support services. Seventy-six countries criminalize same-sex sexual relations between consenting adults, most countries criminalize some aspect of sex work and most impose criminal penalties on people who are drug-dependent. Not only do these laws marginalize and expose members of key populations to violence, criminal sanctions and prison, they also result in the exclusion of these groups from national economic, health and social support programmes.

59. Consistent with commitments made in the 2011 Political Declaration on HIV and AIDS, countries should immediately review national legal and policy frameworks and, where indicated, enact strong anti-discrimination provisions and repeal or revise other laws that impede sound HIV responses. As only 51 per cent of countries had a legal aid system in place in 2010 for HIV-related cases, countries should strive to provide legal aid and invest in legal rights literacy programmes for people living with HIV and for key populations. Urgent efforts are also needed to sensitize judicial personnel and law enforcement officials.

60. Several important examples of human rights leadership have recently emerged. Thirty-two countries have developed national or sectoral policies and legislation to encourage stakeholders in the workplace to take steps to eliminate stigma, protect human rights and facilitate access to services. In Rwanda, civil society organizations have joined with the bar association and other partners to support legal services, legal literacy and capacity-building in the justice sector. The decriminalization of drug use in Portugal has been associated with a decline in the rates of lifetime drug use and increases in the number of people accessing treatment for drug dependency. Fiji decriminalized homosexuality in 2010, New Zealand reformed its laws to

decriminalize sex work and projects in the Philippines and Thailand work to sensitize law enforcement to the needs of key populations. In South Africa and Brazil, the International Labour Organization Recommendation concerning HIV and AIDS and the world of work, 2010 (No. 200) has been cited in court cases that reversed discriminatory actions against workers based on their HIV status.

61. Recognizing the urgent need to align legal frameworks with principles of human rights and a sound response, UNDP is leading an 18-month initiative, the Global Commission on HIV and the Law. The Commission will soon develop actionable, evidence-informed, rights-based recommendations for effective AIDS responses.

62. In addition to reforming laws and policies, important advances have been made towards expanding the evidence base for community-based programmes to alleviate HIV-related stigma. In particular, innovative anti-stigma projects in Afghanistan, Bangladesh, India, Nepal, Pakistan and Sri Lanka have generated insights and lessons that are informing anti-stigma efforts in other regions.

63. As at November 2011, 47 countries, territories and areas continued to impose discriminatory restrictions on the entry, stay or residence of people living with HIV. Since the 2011 special session, Fiji has removed HIV-related travel restrictions from its national AIDS decree. This courageous action follows the examples of other countries that have removed HIV-related travel restrictions since January 2010, including Armenia, China, Namibia, Ukraine and the United States of America.

I. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response

64. The response to HIV is inextricably linked with the broader development and human rights agenda. In particular, progress in the HIV response advances, and benefits from, progress towards other Millennium Development Goals.

65. The 2011 Political Declaration on HIV and AIDS pledges action to leverage the response to strengthening health and community systems and to integrate HIV into other health and development efforts. The response to HIV has brought unprecedented attention to the needs and rights of young people, women, sex workers, men who have sex with men, people who inject drugs, prisoners and numerous other populations. The response has also strengthened health governance; underwritten the training of tens of thousands of health workers and supported innovative human resource strategies; improved systems for health surveillance and for procurement and supply management of health commodities; and improved laboratory capacity and physical infrastructure of clinics.

66. To improve health outcomes, comprehensive, people-centred services are needed that integrate HIV with services for tuberculosis, sexual and reproductive health, including women's and children's health, and non-communicable diseases, such as drug dependency, cancers and cardiovascular diseases. Innovations in health systems arising from the scale-up of HIV treatment, such as the engagement of communities in service provision and demand creation, service decentralization and measures to enhance the affordability and accessibility of essential health commodities, are already contributing to improvements in programmes for other chronic and non-communicable conditions.

67. Social transfers of food, cash or vouchers, combined with community-based care, help to overcome barriers to service access and treatment adherence. Although social protection has a clear role to play in strengthening the response, intensified collaboration between HIV and social protection experts and stakeholders is necessary to ensure that social protection programmes respond to the needs of individuals and households affected by HIV.

68. The epidemic's effects on children demand continued action and commitment. There is encouraging news, as the number of children orphaned by HIV appears to have peaked in 2009 at 17 million, with a modest subsequent decline to 16.6 million by 2010. This was attributable primarily to the expansion of antiretroviral treatment and programmes to prevent new HIV infections among children. However, country reports indicate that most households with children affected by HIV do not receive assistance and there continue to be millions of new orphans every year. The most effective and non-stigmatizing approach involves situating HIV assistance within broader programmes that address the needs of all vulnerable households.

III. Mutual accountability and engaging diverse stakeholders in the response

69. Achieving a world with zero new infections, zero discrimination and zero AIDS-related deaths will require a collective response, as no sector or stakeholder category has the capacity on its own to undertake or oversee the urgent push to achieve agreed AIDS targets for 2015. Every stakeholder has a critical role to play in ensuring success, and each must commit to principles of mutual accountability, inclusivity, transparency and coordination in the response.

70. Leadership for results is evident across the breadth of the response. In recent months, parliamentarians in India convened a new forum to raise HIV awareness among political decision makers, and the Prime Minister of Mozambique convened a national dialogue to accelerate progress towards the targets in the 2011 Political Declaration on HIV and AIDS. In the face of economic challenges, some donors are also stepping up to the challenge: in 2011, the United States committed to reach at least 6 million people living with HIV with antiretroviral treatment by December 2013 and unveiled a new prevention strategy for its international HIV assistance that is aligned with the principles in the investment framework. The Ministers of Health of Brazil, China, India, the Russian Federation and South Africa formally committed to work together to fully implement the 2011 Political Declaration.

71. Civil society continues to play a leading role, bringing its unparalleled insights, passion and drive to the response. Organizations of people living with HIV have spearheaded the roll-out of the People Living with HIV Stigma Index and promoted the implementation of a holistic, rights-based approach known as "Positive Health, Dignity and Prevention". Civil society groups continue to lead advocacy efforts, at the country level and also globally, where diverse advocates have united to urge concerted action to secure the rights to treatment, non-discrimination and participation. In many countries, civil society organizations have an important role in service, underscoring the need for Governments to work with non-State actors to build sustainable national and local responses.

72. The active engagement of regional institutions is also vital to continued and accelerated progress. In February 2012, Governments of Asia and the Pacific endorsed a road map for improved coordination to accelerate regional progress towards the targets in the 2011 Political Declaration on HIV and AIDS. Similarly, African countries have joined together in a regional plan to eliminate new infections in children; revitalized the AIDS Watch Africa initiative; and joined together under the African Commission on Human and Peoples' Rights to establish the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV.

IV. Measuring results

73. Regular reporting on progress has helped to advance success in the HIV response, enhanced accountability and promoted greater transparency. By engaging civil society and other non-governmental partners, national reporting on core indicators has also contributed to a more inclusive and effective response.

74. The 2011 Political Declaration on HIV and AIDS reflects and reinforces the principles that have made the AIDS response so innovative, robust and successful. To measure the 2011 Political Declaration, the Monitoring and Evaluation Reference Group, supported by UNAIDS and bringing together experts from national Governments, civil society and international organizations, has developed a revised set of Global AIDS Response Progress Reporting indicators. These indicators have been integrated with the WHO system for health sector reporting. Progress reports from countries will be summarized in annual reports to the General Assembly to inform its annual debate on progress in implementing the 2011 Political Declaration.

75. Given the urgency of expediting progress towards the 2015 deadline, additional efforts should be taken to maximize the utility of national reporting to accelerate progress towards agreed targets. In particular, it is imperative that regional institutions increase their involvement and visibility with respect to monitoring and reporting on progress.

V. Recommendations

76. 2011 was a remarkable year for the AIDS response. More than 7 million people were receiving antiretroviral treatment and new scientific advances confirmed the potential of treatment for preventing new HIV infections. Great promise and hope were reflected in the ambitious targets and commitments of the General Assembly Political Declaration on HIV and AIDS, encouraging world leaders and community activists to speak of the beginning of the end of the AIDS epidemic. However, much urgent work remains. The Secretary-General calls on the international community to now stand up to meet the commitments it has made. It needs to do so in ways that shift from charity to justice and that build ownership and shared responsibility for a more sustainable AIDS response, in line with the call for a new social contract made in the Five-Year Action Agenda. In particular, the Secretary-General urges all stakeholders to join hands to:

(a) **Dramatically strengthen and intensify efforts to prevent new HIV infections**. By building on the advances of recent years in promoting safer sexual

behaviours, prevention programmes should enhance efforts to reinforce, sustain and extend behaviour change by promoting social norms of gender equality and mutual respect. Prevention programmes should be better focused on the localities and specific communities where new infections are occurring. Renewed determination is needed to eliminate new infections in children and keep their mothers alive in the 22 priority countries identified in the Global Plan, with particular efforts to ensure commitment and energy in all countries. Stakeholders in the response must summon the wisdom, courage and commitment required to implement strong, evidence-informed prevention programmes that empower key populations to protect themselves and their partners from HIV, including specific focus on the three key populations at higher risk of HIV infection recognized in the 2011 Political Declaration on HIV and AIDS: men who have sex with men, sex workers and people who inject drugs;

(b) **Renew and strengthen determination to deliver HIV treatment, care and support services to those who need them**. To reach the 2015 target of ensuring that 15 million people are on antiretroviral therapy, all partners must work together to enhance the efficiency and accountability of treatment scale-up, accelerate progress towards universal knowledge of HIV status, use lessons learned to increase treatment adherence and retention in care and implement specific steps to ensure equal treatment access for key populations and other socially excluded groups. Urgent attention is needed to catalyse the next phase of HIV treatment and care. Intensified research should focus on the development and deployment of simpler, affordable diagnostics and optimally effective combination regimens; countries should maximize use of flexibilities under international intellectual property provisions to lower the costs of medicines; and communities must be engaged and mobilized to support treatment scale-up. All countries must put into place proven programmatic strategies to increase timely diagnosis, prevention, treatment and cure of tuberculosis cases among people living with HIV;

(c) **The world must move from rhetoric to reality in the commitment to a rights-based approach to HIV**. All countries should undertake an immediate, comprehensive review of national legal and policy frameworks to remove obstacles to effective and rights-based AIDS responses. Meaningful laws prohibiting HIV-based discrimination should be in place in all settings and should receive implementation support and include concrete mechanisms and services to increase access to justice for all people affected by the epidemic. Countries and donors should work together to focus substantial new funding on community-based programming to overcome HIV-related stigma, promote norms of gender equality and eliminate gender-based violence. Criminal laws and other legal or policy impediments that act as obstacles to the effective enjoyment of health and other human rights for key populations at higher risk should be revised or eliminated. By leveraging opportunities through the AIDS response to forge stronger linkages with other health and social and human rights campaigns, women and young people must be empowered and gender equality promoted;

(d) **A new approach to HIV investment is needed that will mobilize necessary resources, enhance the strategic use of resources and accelerate Africa's transition to stronger ownership and sustainability of the response**. All current and potential providers of HIV funding, including international donors, emerging economies, affected countries and the private sector, should contribute financially to the response, taking advantage of opportunities to mobilize additional

resources and in accordance with each partner's capacity. While remaining energetically engaged as partners in the response, international donors and technical agencies should support countries to enhance coherence and control of programming and resources and to maximize value-for-money for results. Through such tools as the investment framework, international partners should support countries to develop robust investment cases to inform and accelerate programmatic scale-up, enhance rigorous and strategic prioritization and optimize synergies through programme integration and critical enablers. With the support of the international community, countries and partners in sub-Saharan Africa should leverage broader development efforts in the region to foster new industries and knowledge-based economies. Urgent efforts are needed to scale up domestic and regional production of antiretroviral drugs in sub-Saharan Africa and to increase South-South technical cooperation;

(e) **New partnerships and collaborative relationships should be forged that respond to the shared responsibility of HIV and reduce risks and advance protections for vulnerable people**. HIV and other health issues need to figure prominently in major international, regional and national forums and in the formulation of the post-2015 development agenda. We must invest in partnerships in which the United Nations, civil society, Governments, academia and the private sector work to address deep-seated issues such as empowering women and young people through strengthened linkages with other health and social movements, and the wider human rights campaigns. Relevant stakeholders also need to confront increased risk and vulnerability in conflict and post-conflict settings and ensure that HIV programmes become an integral part of all disarmament, demobilization, reintegration and peacebuilding processes and security sector reforms, using HIV programmes to strengthen the capacity of peacekeepers and uniformed personnel as agents of positive change.